STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375243	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jan Frances Care Center	815 North Country Club Road Ada, OK 74820

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 07/28/25 at 4:01 p.m., the Oklahoma State Department of Health was notified and verified the existence of an immediate jeopardy situation related to the facility's failure to provide supervision and interventions to prevent resident-to-resident abuse. Resident #1 and Resident #2 became involved in an altercation over cigarettes on 07/19/25. Resident #1 hit Resident #2 with a wet floor sign, causing a fracture to Resident #2's left arm. The facility did not implement interventions to prevent another incident. On 07/27/25, Resident #1 and Resident #4 were involved in an altercation over cigarettes which resulted in the residents slapping each other. No interventions or additional supervision were implemented to prevent another resident-to-resident altercation. On 07/28/25 at 4:11 p.m., the administrator was notified of the immediate jeopardy and was provided the immediate jeopardy template. On 07/30/25 at 12:16 p.m., an acceptable plan of removal was approved by the Oklahoma State Department of Health. The plan of removal, read in part, July 29, 2025Jan [NAME] Care CenterAmended Plan of Removal-Abuse/Resident to Resident Altercation Completion date 07-29-2025 8:00 p.m.All Staff EducationAbuse and Neglect Policy & ProceduresResident-To-Resident AltercationsAll staff will be educated on ensuring the safety and well-being of all residents by preventing, identifying, and managing resident-to-resident altercations. When a resident poses a risk to others, immediate action will be taken including 1:1 supervision and, if necessary, removal or transfer to a more appropriate setting. All staff will be educated on the facility abuse policy, how to identify abuse, the potential for abuse, and the prevention of abuse. [Name withheld], Regional Nurse, will be the instructor for both inservices. [Name withheld] is the Abuse Coordinator and will receive additional education from [name withheld], Regional Nurse. A sign in sheet will be utilized for staff that are currently in the facility. Any remaining staff will be called to the facility for education; or educated over the telephone. Employee names and the time of the telephone call will be documented. This education will be completed by 4:00 p.m. on 7-29-25. Currently in progress:All residents will be assessed for active behavior issues to determine the risks for future altercations. The physician will be notified if any resident is displaying current behaviors. Interventions will be implemented and care plans updated as needed. This was completed on 7-28-25 at 6:00 p.m. Resident #1 will be discharging to another skilled facility today 7-29-25 at 4:00 p.m. Resident #1 is being monitored 1:1 by a CNA and will be monitored until time of discharge today. Resident #1's care plan has been updated. Resident safe surveys were completed by [name withheld], Administrator on 7-28-25 by 6:00 p.m. Non-verbal communication tools such as an emotions picture card will be used to determine if non-verbal residents feel safe. Skin assessments will be completed for all residents that are cognitively impaired to check for bruising or skin tears to rule out physical abuse. Skin assessments were completed by the Regional Nurse, [name withheld]. They were completed 7-29-25 before 8:00 p.m. Upon completion of the immediate corrections, audits and observations will be continued by the Administrator and Interim Director of Nursing for the next 90 days. On 07/31/25, after interviews with facility staff, review of staff in-services and sign-in sheets, resident behavior assessments, resident skin assessments, safe survey forms, and documentation related to one-on-one supervision of Resident #1 prior to discharge, the immediacy was lifted, effective 07/29/25 at 8:00 p.m The deficient practice remained as a pattern harm level with the potential for more than minimal harm.Based on observation, record review, and interview, the facility failed to provide supervision and interventions to prevent resident-to-resident abuse for 3 (#1, 2, and #4) of 4 sampled residents reviewed for abuse. The administrator reported two incidents of resident-to-resident abuse in the past 90 days. Findings: An Abuse - Reportable Events policy, dated 08/2019, read in part, It is the responsibility of all facility staff to prohibit resident abuse or neglect in any form, and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse or neglect caused by another person.It is the responsibility of all facility staff to prohibit resident abuse, neglect, exploitation, and misappropriation of resident's property in any form .All residents will be immediately protected from harm .If another resident is the alleged perpetrator, they shall immediately be assessed for treatment options. The safety and protection of other residents is the home's primary concern.1.A care plan, dated 04/22/25, showed Resident #1 exhibited agitation and aggressive behaviors. The care plan was updated on 07/21/25 and showed the resident was combative and had been in an altercation with another resident (Resident #2). A quarterly MDS assessment for Resident #1, dated 05/10/25, showed the resident had diagnoses which included chronic

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility failed to report an incident of misappropriation of property for 1 (#4) of 2 residents sampled for misappropriation of funds. The administrator reported two incidents of misappropriation of resident funds. Findings: An Abuse - Reportable Events policy, dated 08/2019, read in part, It is the responsibility of all facility staff to prohibit resident abuse, neglect, exploitation, and misappropriation of resident's property in any form; and to report in accordance with the law any incident/event in which there is cause to believe a resident's physical or mental health or welfare has been or may be adversely affected by abuse, neglect and/or exploitation caused by another person .All alleged allegations of abuse will be reported to the appropriate state agency and to all other agencies as required by regulation. An OSDH incident report form, dated 06/27/25, showed a previous staff member, social services #1, had taken money from residents on two different occasions. The report listed only one resident by name and gave details of that investigation. A quarterly MDS assessment for Resident #4, dated 07/17/25, showed the resident had diagnoses which included Parkinson's disease, diabetes, chronic obstructive pulmonary disease, anxiety, and depression. The assessment showed the resident had a BIMS score of 13, which indicated the resident was cognitively intact. A care plan for Resident #4, dated 07/28/25, showed the resident had a behavior of manipulation or fabrication toward staff and other residents. On 07/28/25 at 4:15 p. m., the administrator was asked which residents had money taken from the previous social services staff, as only one was listed on the incident report. The administrator reported it was Resident #4, but the administrator was not working at the facility during that time and was not familiar with how the incident was handled. On 07/31/25 at 4:20 p.m., the administrator and regional director of operations were interviewed regarding the social services staff member taking money from Resident #4. The regional director reported the ombudsman informed them about the incident and offered to report the incident to APS. The regional director reported they did an investigation, looked into the resident's bank statements and withdrawals, and ultimately the staff member admitted to taking the money from Resident #4. The regional director reported this was against their policy and the staff member was terminated. The regional director stated they did not report the incident to OSDH, as they thought the ombudsman would report it. On 08/01/25 at 8:45 a.m., the administrator reported they were not working at the facility when the incident occurred with Resident #4 and the previous social services staff. The administrator stated they were the one that reported the incident involving a different resident, and if they had been at the facility, they would have done the same related to the incident with Resident #4. On 08/01/25 at 10:25 a.m., the ombudsman reported they had gone to the facility when Resident #4 called them to say the social services staff had asked to borrow money. The resident told the ombudsman they had given the staff member their debit card and thought they would pay back the money. The ombudsman reported they offered to submit an APS report for the facility regarding the incident. The ombudsman reported they did not know if the facility called the police or did an investigation, but they should have. On 08/01/25 at 10:40 a.m., Resident #4 reported they thought they were friends with the previous social services staff and did not hesitate to give the staff member their debit card. The resident stated they had learned a lesson and would not do it again.